HEARTACHES
MEDIATION

Confidential Information for Dr. Dellahunt
Farmington Hospital

You lie awake at night regretting two decisions: to leave Arkansas and to undertake pediatric cardiac surgery. You had always wanted to be a physician. You persevered in all pre-med courses, which did not come easily, and felt fortunate to be accepted into the University of Arkansas's medical school. Once there, you were drawn to surgery's excitement and dramatic curative impact. An Ohio native, you enjoyed Arkansas's slower lifestyle and mild winters and stayed on for general surgery and cardiac surgery residencies. You became a surgeon at Little Rock Hospital, performing some general surgery but mostly adult cardiac surgery. You met your wife in Little Rock, where she was an education major and earned her teaching certification. You now have three children, between ages 10 and 16.

Three years ago, you began looking into a move back to Ohio to be closer to your parents, who were becoming frail, and other extended family. You were delighted to learn of an opening in Farmington, where you had gone to high school. The only issue was Farmington Hospital's desire to have you perform both adult cardiac surgery and pediatric cardiac surgery. Farmington Hospital's Chief of Surgery, Dr. Knowles, said your current lack of experience with pediatric heart patients shouldn't be a problem. The hospital planned to ramp up its adult heart surgery service first and then move to pediatrics. There would be plenty of time for you to be trained for surgery on smaller hearts. You were also told that the hospital was hiring Dr. Rasheesh, a surgeon with considerable training and experience in pediatric cardiac surgery, and that you would be able to work together. Your interview visit was delightful. You heard from extended family there that Farmington Hospital was known to be a collegial, informal place to practice medicine with a good reputation in the Community. You accepted the job, with full clinical privileges.

Within the first year at Farmington, you were sent to at least three training sessions at Philadelphia Children's Hospital to learn pediatric cardiac surgery procedures. This was essential because cardiac surgery for infants and children involves different procedures from those done in adults. The small size of an infant's or a young child's heart was far from the only major challenge. In an adult, open heart surgery typically involves one or more by-pass attachments, clearing out arteries (basic plumbing), or repairing a ruptured aorta. In children, open heart surgery must repair a wide range of congenital defects rarely seen in adults and never as severe as defects often seen infants. (Unless it has been repaired, people do not live to adulthood with defects like those in neo-nates, infants, or young children.) Among the more challenging procedures are one designed to repair "Transposition of the Great Arteries" ("TGA"), the Arterial Switch, and one designed to repair an "Atrio-Septal Ventricular Defect" ("AVSD"). You studied these and other procedures diligently and closely observed them in Philadelphia. Once the pediatric cardiology service began at Farmington Hospital, you either observed or were assisted by Dr. Rasheesh a number of times before performing these procedures yourself.

Everything seemed to go well in Farmington for the first eighteen months, including your first six months in pediatric cardiac surgery. Dr. Rasheesh was easy to work with and a gracious teacher. You were both experiencing somewhat higher than anticipated morbidity, but this is par for the course in open heart surgery. That is why it is important to remain detached from emotions and the patients' families; you cannot afford to be distracted.

Over time, you began to suspect that your own morbidity rate in pediatric surgery was slightly higher than Dr. Rasheesh's, though you hadn't kept track of his precise numbers. Dr. Rasheesh assured you not to be alarmed, because you had both had a run of particularly difficult cases – children with unusually complex heart defects. He noted that success rates can be misleading when taken from a small data pool, and there had been fewer than 15 Arterial Switch surgeries in the first year. He also noted there is an inevitable learning curve for this type of surgery, no matter how skillful the surgeon. It is generally thought that at least 30 of each type of complex surgery per surgeon, per year, is necessary for anyone to reach and maintain optimum skill.

After one unsuccessful Arterial Switch procedure last year, in which the neonate presented the most challenging arterial characteristics you had seen, you sent an email seeking guidance from a Philadelphia surgeon who has provided the earlier training. That surgeon wrote that he had a number of extremely difficult cases scheduled that week and invited you to observe. You went back to Philadelphia for the week and witnessed these newest Arterial Switch techniques in the operating room. You later carefully reviewed video recordings of the surgeries at home. This training seemed helpful. You were able to incorporate new techniques into your next few operations, which were successful.

The downturn for you began eighteen months after arriving at Farmington. Dr. Rasheesh informed you confidentially that he was looking to phase out of pediatric cardiac surgery. He and his wife were having some trouble trying to start a family, after having lost a nearly full-term baby in utero, several months earlier. For him, open heart surgery on newborns with severe heart defects was becoming emotionally overwhelming; he could no longer distance himself from the families' anguish. You suspected he was suffering from depression. Thus, more of the pediatric cardiac cases were referred to you, and Dr. Rasheesh was rarely there to assist you in the operating room. By then, you felt well trained and competent at applying the techniques you had learned. When two more infants died within hours after surgery, Dr. Rasheesh reviewed the files and assured you that he wouldn't have done anything differently. They were very difficult cases, requiring lengthy time to correct the full range of defects, and the babies were in poor condition.

At about this time, one of the surgical team's anesthesiologists, Dr. Stephen Wilson, decided to self-appoint as master judge of surgeons. Dr. Wilson began questioning you about why your surgeries took too long, and why the infants arrived at the ICU in difficult shape. Wilson and at least one of the nurses began challenging your instructions and charting in the ICU. They went out of their way to congratulate you on successful outcomes: "Hey, Dellahunt finally got a hit, never mind the batting average…" Obnoxious. At routine surgical

staff meetings, Dr. Wilson started suggesting that the attending nurse mind the clock and call out "time elapsed" at fifteen-minute intervals, to speed surgery along. You objected strenuously to any suggestion that you weren't proceeding as rapidly as possible. Dr. Wilson also pushed Dr. Knowles to purchase newer heart lung machines for neonates and special neonatal ventilators, stating that the machines in use were "jerry-rigged." You immediately suspected that was a way for Wilson to cover anesthesia slip-ups during surgery or lapses in care in the ICU. You claim no expertise in the operation of those machines, but you know the hospital paid a great deal to have them upgraded and retrofitted for infants.

Over time, you came to believe other factors at Farmington Hospital were affecting outcomes and morbidity statistics. The ICU was your number one suspect. It is hard to put your finger on what was not being done well in there, but you do not think the nursing staff or ICU physicians are too sharp. You noted your own mildly disappointing success rates in *adult* cardiac surgery at Farmington compared to Arkansas. Yet your ability to perform adult cardiac surgery wouldn't have declined on the trip from Arkansas. Your surgical abilities are the same. So, the cause was either an unlucky run of very bad adult hearts, or something different about care at Farmington Hospital. One or both may be true.

Dr. Wilson did not stop the campaign against you. At every morbidity conference and, you suspect, in various back-room conversations, Wilson was hyperbolically critical, arrogant, and "holier than thou." Wilson forced you to discuss every twist, turn, and hole in each patient's heart defect to explain why the particular case was unusually difficult or how the patient's condition affected his tolerance for surgery and recovery. Sometimes you think Wilson forgot these were often very tiny neonates, or underweight infants weakened by their struggle to live with compromised hearts.

The only bright spot in all of this was your other surgical team colleagues, including Chief of Surgery, Dr. Knowles, who supported you against Dr. Wilson (and ICU nurse Stanton, who took Wilson's side). Even though you had not been there long, they listened and accepted your explanations of what had occurred in surgery, and why morbidity was unavoidable in particular cases. You were grateful for their professional courtesy and personal loyalty.

The struggle between you and Dr. Wilson came to a head the evening before the Fairday surgery. Dr. Wilson marched into a morbidity conference on one of your recent Arterial Switch procedures, with a smug smile, waiving a report. "This does it," Wilson announced. "I hope the hard numbers will convince everyone that we are ethically and morally obligated to stop this one [pointing at you] from performing surgery here." Wilson passed the report around, and proudly explained that they had gone through hospital files, compiled statistics on morbidity in pediatric cardiac surgery over the past two years and compared these to morbidity percentages in major pediatric cardiac surgery centers. According to Wilson, the morbidity rate in most major centers for Arterial Switch surgery is 20 – 21%, and as low as 15% in some centers within the past few years. Wilson asserted the mortality rate at Farmington Hospital had been 35-40% during their tenure. In other major centers, the surgery lasts 4 to 4 ½ hours; at Farmington, it averages 6-6 ½ hours, sometimes longer.

Wilson also claimed not to see anything so unusual about the heart defects presented. Wilson stood up and dramatically made a formal proposal that the surgical team vote to stop you from performing Arterial Switch operations, effective that minute.

You were outraged. This was an ambush. It meant that Wilson had broken into your files, Rasheesh's files and those of other physicians. Outrageous! And who appointed Wilson judge of what was a difficult case and what was not?" Moreover, Wilson's report threw Rasheesh's numbers and your early numbers together. There had been a learning curve, but your numbers had improved over the previous six months, ever since your visit to Philadelphia. The most recent morbidity was anomalous and completely explainable.

Fortunately, the rest of the team was also outraged by Wilson's aggressive move. They told Wilson to sit down and be quiet and heard your explanation of the history and of the particular case. They voiced their respect for your decision to gain additional expertise in Philadelphia and noted your recently improved statistics. As you had explained, over the past six months your numbers were about at the national average, including that last unavoidable death. Wilson's proposal was defeated. The rest of the team voted not to bar you from the Arterial Switch surgery. You operated on a six and half month-old patient, Joshua Fairday, the next morning.

Perhaps you should have known the stars would not line up on your side that day. Joshua Fairday died in the ICU, despite your effort to use the utmost care during his Arterial Switch surgery. Joshua's heart condition was extreme.[1] In addition to classic TGA, the hole in his heart had enlarged, and the heart muscle and attachment point had several anomalies that were not discussed in the cardiologist's report (one could barely make out the details on the ultrasound). When you met with Joshua's parents, the day before, you described the Arterial Switch procedure, and let them know it is risky and delicate surgery. You explained that, despite the risks, it was the best hope for Joshua's becoming healthy.

You were very nervous during the surgery, concerned that Joshua might expire on the table. The surgery took longer than you would have liked. You had to be careful. In fact, you had called for a cardiologist consult during the surgery and that took some time. Numerous subtle aspects of the heart defect required repair. Later, you were angry when one of the ICU nurses challenged your chart notation of Joshua being "pink" and having "tolerated surgery

[1] Like most infants born with TGA, immediately after birth Joshua had been treated with Prostaglandin E to keep the arterial duct open. This is usually rapidly effective in improving the blood oxygenation by encouraging more blood flow to the lungs and more flow through the hole between the two atriums (which is common in hearts with TGA). At that point, Joshua received a cardiac catheter – a type of closed heart surgical procedure to help him survive prior to the open-heart Arterial Switch surgery that Joshua's condition required. The Arterial Switch is generally performed when a baby is three to four months old. However, the cardiologist had agreed with Joshua's mother that he seemed small and thin, and that it might be better for him to grow a bit before surgery. Surgery was finally when Joshua was 28 weeks – 6 ½ months old. In your mind, this was later than optimal, for it meant that Joshua's had been functioning for too long with a weak heart.

well" when Joshua entered the ICU. Joshua looked so much better than you would have expected when the surgery was finally finished. You too were anguished when you learned that he was failing in the ICU, about an hour after surgery. The nurse sounded an alarm. The anesthesiologist, Dr. Wilson, and various doctors and nurses rushed in, and began manipulating Joshua's chest, administering medication, and finally giving him electric shock treatment, to no avail. You came in as the ICU team was working on Joshua, turned to his parents, and said, "I am so sorry. Joshua was a sick little boy. His poor heart must have been tired out." You looked down, and slowly walked away.

The next day, the entire surgical team announced their refusal to operate with Dr. Wilson as anesthesiologist. Nurse B.J. Stanton, Dr. Wilson's only friend, announced they would no longer work on pediatric ICU patients. Virtually no one else would speak to Wilson. You notified Dr. Knowles that you would stop doing the Arterial Switch operation, though you were still open to performing other, less complex pediatric cardiac procedures. A routine morbidity conference was held on the Fairday case shortly thereafter. You reviewed the complexities of Joshua's heart condition with the team. They seemed to understand the difficulties of his case and did not challenge your conclusions, perhaps because you informed them of your decision to stop performing the Arterial Switch.

Eight months ago, five months after Joshua's death, you noticed a column in the local paper called "Comings and goings down at Farmington Hospital." The columnist noted that the pediatric anesthesiologist, Dr. Wilson, resigned after only a short time. Wilson had filed suit against the hospital for effectively terminating or forcing Wilson's resignation after Wilson uncovered "just how down on the farm and backward in time" the practice was at Farmington. Colleagues accused Wilson of being difficult for calling them on their botch ups. Wilson claimed to have evidence that the surgeons at Farmington Hospital performing heart surgery on babies had much higher mortality rates than surgeons in "quality" hospitals elsewhere. Wilson noted as proof that one of the surgeons had finally admitted being unable to handle neo-natal heart surgery, and was giving it up, but "not before they decided to sack me, because secrets are more important than patients in this terribly chummy backwater town." Hardly an in-depth report, the article cited an anonymous nurse who stated that it was not responsible to use the same ICU and the same surgeons for tiny babies as for adults, and that they were constantly depressed from seeing so many babies die on the operating table. "Yes, it's part of the risk you take when you work in the ICU she said, but there seems to be a curse on Farmington." The balance of the article quoted the Medical Staff Director and other hospital officials who asserted that, while they couldn't comment on particulars, "It should be obvious to the public that Dr. Wilson is a bitter and justly terminated former employee, pointing fingers at everyone else."

The same paper later published a letter by Joshua Fairday's parents "alerting parents in town to the danger of taking their children for surgery at Farmington Hospital." Thus, you were not surprised at being served with the complaint in a medical malpractice wrongful death suit, filed by Joshua Fairday's parents. The complaint was terrible, stating that you were incompetent, unqualified, grossly negligent, and even that you intentionally caused the

death. You couldn't bear to read it through. Distraught, you went immediately to Dr. Knowles, who listened sympathetically. Dr. Knowles said notice of the complaint had also been served on the hospital. You were advised to put your medical malpractice insurance carrier on notice. Dr. Knowles offered to help you select a defense attorney from among those on the insurer's approved list.

A few months ago, you met with attorney Jan Carsen, who had been recommended by Dr. Knowles. Together, you reviewed the terms of your insurance policy, and you provided the information needed to draft an answer to the complaint. The attorney explained that they represent you and the insurance carrier. However, under the terms of your policy, the case cannot be settled without your approval. The attorney also noted that if there were a coverage issue, you might need independent counsel. But, fortunately, at this point your medical malpractice policy seemed to cover the claims made. Your policy limits are $2 million "per occurrence," which could be needed in cases of brain damage or debilitating physical injuries.

The attorney told you that wrongful death claims on behalf of deceased children are typically settled for far, far less than that. You expressed worry about settling due to the national registry on which settlements or liability verdicts are reported. You don't know exactly how the system works. You have never faced a malpractice claim before.

In a later meeting with the attorney, you carefully reviewed Joshua Fairday's case and provided all relevant details (stated above) about your medical training and experience, before and after you began at Farmington Hospital. Not long after that, the attorney informed you that, during an early case conference, the court magistrate had suggested mediation. Based on the attorney's advice, you agreed to mediate, and authorized them to approve any mediator who would be fair and not biased toward the plaintiffs.

Attorney Carsen also explained the magistrate had permitted some preliminary, informal discovery in preparation for the mediation. Carsen and the hospital's counsel had initially objected, but plaintiff's counsel made an oral "offer of proof" to the magistrate, describing Dr. Wilson's statistical study and the meeting on the evening before Joshua's surgery. The magistrate ordered the defense attorneys to provide the requested information, recognizing it would be protected, at least temporarily, under a mediation privilege.

You were concerned to learn the magistrate was impressed by mention of Wilson's statistics. As you told your attorney, it is important to understand that statistics work in funny ways. When absolute numbers of surgeries performed are small, a short run of bad luck and a small number of difficult cases can dramatically affect percentages**.**

The mediation was scheduled for a few months later, to give both sides time to agree upon a mediator and to have Joshua's medical records and other documents reviewed by independent experts. The lawyers agreed to obtain expert opinions on the medical issues and to exchange them a week prior to the mediation. Your attorney suggested (and you

agreed) that, for the purposes of the mediation, you and the hospital might retain the same expert to review Joshua Fairday's medical records, including your notes and other documents relating to his surgery and treatment in the ICU.

Last week, your attorney sent you the experts' reports from both sides. You were relieved to see that your defense expert concluded that Joshua Fairday's was a serious TGA defect, with a seriously enlarged hole between the heart's chambers, and that his heart muscle appeared to have been in weakened condition prior to surgery. The expert, a semi-retired cardiologist from Columbus, stated that the autopsy report included no evidence of surgical technique that fell below the standard of care.

You were disheartened but not surprised to see that the plaintiff's experts, a pediatric cardiologist and a surgeon from Harvard Medical School and Boston Children's Hospital, disagreed. They stated Joshua's TGA was not worse than most others repaired in Arterial Switch surgery by experienced surgeons. They also reviewed Joshua's vital signs and test results from doctor's visits in the months prior to surgery and on the morning of his admission. They disagreed with any notion that Joshua was in a weakened condition prior to surgery, though they noted that waiting 6½ months for the Arterial Switch is a bit long and can take its toll on the patient. They also disagreed your notation of Joshua being "pink" and having gone through surgery well, based upon his troubling vital signs in the ICU immediately after surgery. The experts dismissed the claim that the cardiologist's reports and tests had missed subtle aspects of Joshua's heart defect, making them unforeseeable. "Dr. Dellahunt may not have studied the reports or the ultrasound pictures carefully enough, but to an experienced reader of such documents, all of the necessary information was present." Finally, the surgeon criticized the length of the surgery as excessive – 7 hours under general anesthesia in the operating theater and 6 ½ hours on the heart lung machine. He noted that the length of surgery indicates lack of surgical expertise and "falls below the current standard of care" barring unforeseeable or unusual characteristics of the TGA defect.

That phrase "below the standard of care" and the words in the complaint, "intentional" and "negligent," have been ringing in your head. You have barely slept. Your attorney told you this is the usual medical malpractice language, and the parents are emotional, wanting to blame someone else for their son's congenital defect. The case will become a battle of the experts. While acknowledging any case has risk and Wilson's statistics do not look great, the attorney reassured you that juries tend not to find against doctors in their community.

In preparation for the mediation, think carefully about what your interests are and whether you want to settle or not. You don't think you would do another Arterial Switch again because of the trauma this has caused you personally. However, you are terribly afraid of losing your license to practice medicine, or of not being granted clinical privileges to conduct surgery anywhere. Prepare to participate in the mediation, scheduled to take place soon.